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Grief Narratives: the role of medicine in the contemporary policing of grief

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Abstract

Drawing largely on already published literature, the article examines the hypothesis, derived from Frank, that the current proliferation of first person accounts of grief represents an attempt by mourners to recover their voice in the face of grief's medicalisation. The extent of medicine's colonisation of grief is found to be limited. Though some mourners make a point of rejecting semi-psychiatric terms, others use such terms to structure their accounts of grief. A broader analysis shows that the policing of grief often occurs without reference to medical terminology and in several arenas outside the medical: in a patriarchal and controlling general culture, in family dynamics, and in counselling and mutual-help groups. Three issues are looked at in some detail: the role of women's liberation in allowing more expressive and personalised grief talk, the suppression of grief talk in the cause of retaining emotional equilibrium within the family, and the exclusion by mutual help-groups of some accounts even as they include others. Resistance is directed as much to face-to-face policing in families and other groups as to grief's medicalisation.

Grief Narratives: the role of medicine in the contemporary policing of grief

I start with two observations. One is the twentieth century medicalisation of grief. Lindemann (1944), in a frequently cited article, wrote of the 'symptomatology and management' of grief, while Engel (1960) argued that grief shares many of the characteristics of a depressive illness, and therefore is a proper subject for study by medical science, this being as true of uncomplicated as of complicated grief. These two authors were psychiatrists, as have been most of the originators of the major theories of grief: Sigmund Freud (1984), John Bowlby (1969-80), Elizabeth Kübler-Ross (1970),ⁱ Colin Murray Parkes (1972), and Beverly Raphael (1984). Medical ideas include being healed of grief, and a healthy outcome to bereavement. The tearing away of the beloved is portrayed as leaving a scar, which will be healed once the dead are relocated in memory; eventually grief, like a wound, heals, a recovery is made, and the threads of life can be picked up once more. Some wounds heal of their own accord; others need medical assistance.

Even though Parkes is on record as saying that grief is not a mental illness (1994: 17) and even though psychiatry has perhaps not fully recognised the contribution of those of its members who have specialised in this area, the fact remains that psychiatric theories and research conducted by psychiatrists dominate scholarly writings on grief and frequently find their way into popular literature on the subject. Further, bereaved people in the UK are more likely, by a long way, to consult their family doctor than any other professional. More recently, the natural death movement (Albery *et al.* 1993; Walter 1995) has attempted to demedicalise all aspects of death, not least grief, asserting that death, like birth, is a normal and natural occurrence of the life cycle. In this vein, a number of articles and courses on bereavement and articles now start with a ritual critique of grief's medicalisation (e.g. Wolfelt 1998).

My second observation is that a vogue has developed in the last third of the twentieth century for bereaved people, at least in the English speaking world, to tell their story. Both the demand and the opportunities for this have increased significantly. Counselling organisations such as the UK's Cruse-Bereavement Care (founded 1959) and the USA's Widow-to-Widow programme (founded 1967), and self-help groups such as The Compassionate Friends (for parents who have lost a child, founded 1969, and operating on both sides of the Atlantic), attract significant and increasing numbers. A number of organisations now exist which encourage children to speak, paint or model in clay their grief, and fictional stories of grief for children are regularly published (Greenall 1988). The number of autobiographical books and articles in magazines and newspapers in which bereaved people tell their story has also expanded (Holloway 1990). Journalists (Ironside 1996), mountaineers (Ballard 1996) and other public figures produce books, articles, radio and television programmes documenting their journey through grief. If in the mid-twentieth century, grief was supposed to be private (Gorer 1965) or hidden (Ariès 1974), by the end of the century a number of (mainly educated female) mourners were going very public about their story.

Are these two phenomena - medicalisation and the increase in mourners telling their story - connected? Arthur Frank's *The Wounded Storyteller* (1995) prompts the hypothesis that they may be. Frank contrasts modern illness in which the medical story is privileged with the postmodern experience of illness which 'begins

when ill people recognize that more is involved in their experience than the medical story can tell... Postmodern times are when the capacity for telling one's own story is reclaimed.' (1995: 6-7) Frank's heroic postmoderns are reclaiming the experience of their own bodies from medical domination. Is something similar happening in the current proliferation of lay accounts of grief? Can this proliferation be explained as an attempt by mourners to reclaim from doctors the right to describe their own grief? This is the hypothesis to be examined in this article.

The data on which I draw are primarily sociological studies of bereavement in contemporary Britain and the USA, and published personal accounts of grief. These are supplemented by my own observations in Britain in the 1990s, including the responses of participants in workshops on bereavement I conducted 1997-9 and letters sent to me by bereaved people in response to a published article on social barriers to talking about the dead (Walter 1996). I will begin by discussing briefly the extent of grief's medicalisation, and then look in more detail at the various 'policing' activities against which contemporary first-person grief narratives appear to be a protest. The conclusion will discuss the extent to which this is a protest against medicalisation.

LIMITS TO MEDICALISATION

There are obvious grounds for caution in jumping to the conclusion that lay narratives are a protest against grief's medicalisation. First, although bereaved people in Britain and many other western countries are more likely to consult a doctor than any other professional, their motives and their interaction with the doctor have not been researched. It seems to me unlikely, however, that they routinely consult the doctor in order to find a cure for grief. If ill people often think 'I'm ill, I must see the doctor', mourners do not automatically think 'I'm bereaved, I must see the doctor.' They need a doctor neither to diagnose grief nor to prescribe a cure; rather, as with any loss such as divorce or redundancy or indeed any external stressor, it is likely that they visit the doctor for medication to help with associated health problems such as sleeplessness or depression.

Second, unlike many physical and mental complaints, medical interest in grief goes back not centuries, still less millennia, but only a few decades. Though Freud's seminal essay was published in 1917, it is only in the last thirty years that psychiatric theories of grief have been widely disseminated or that bereavement has been included in the general medical curriculum in the UK and the USA (Field 1984).

Third, psychiatrist Parkes (1994: 18) is not alone in maintaining that grief is not a mental illness and that the aim is not, contra most illnesses, to return the mourner as far as possible to the status quo ante. Rather, he describes grief as 'much more like a process through you go, in the course of which you change a psycho-social transition' (1994: 19). The concept of 'the grief process' flows from this idea, implying unpredictability and dependence on the particular circumstances of the individual. As used by a number of theorists and bereaved people, however, it implies a single, predictable process through which all mourners must go and through which experts or other bereaved people can help you. Either way, it implies a psychological rather a strictly medical phenomenon. We might therefore term 'the grief process' a semi-psychiatric concept.ⁱⁱ

If the first three grounds for caution indicate the medicalisation of grief to be far from total, the next indicates that many (by no means all) mourners who wish to tell their own unfettered story now often enthusiastically use, rather than reject, semi-

psychiatric language. Particularly popular are the notion of grief having stages (deriving from Kübler-Ross 1970), the Freudian notion of denial (also part of the Kübler-Ross schema), and the notions of 'the grief process', the resolution of grief, and recovery from grief. (For a brief account of the way these concepts can structure popular accounts of grief in the UK, see Walter [1994: Ch. 5], and in the USA, Wambach [1985].) In a rare, and hence valuable, participant observation study of a widows' self-help group in Arizona, Wambach (1985) found that teaching new members about the stages of grief was one of the main functions of the group, although members varied as to how they saw the rigidity and timetabling of these stages. 'The grief process' and 'the stages of grief' were for them a fact, not a construct used by researchers, practitioners and mourners to make some sense of grief's complex and ever-changing emotions. In a popular culture where child development and other life cycle events are measured according to the norms of developmental psychology, it is perhaps not surprising that a number of mourners also embrace developmental stage theories which provide guidance and assurance as to how they are getting on. In so far as this occurs, we might go so far as to suggest that the anomie and lack of guidance left behind by the loss of Victorian social mourning has for these mourners been filled by the stages and schedules of 'the grief process' as identified in psychiatric lore. For them, grief is ordered by the dictates not of social mourning but of an inner psychological process.

Jalland (1996: 12) found that the material written by and for upper class Victorian mourners offered four primary sources of consolation: first and foremost, a religious belief in a happy family reunion, followed by the healing power of time, private and shared memory, and the sympathy of friends and relatives. An American study of late twentieth century literature on maternal grief, however, found three very different kinds of comfort to be prominent: stories of other people's loss, information about the stages of grief, and affirmation that the emotions of grief are normal (Simonds and Rothman 1992: 158). These three comforts are also provided in a wide range of late twentieth century British pamphlets, booklets and popular books for the bereaved. Listening to other mourners' stories and finding out about the semi-psychiatric stages of grief are therefore not necessarily in conflict and may be indulged in by the same reader (Walter 1994: 126-8). Indeed, psychological models that identify the mourner's grief with that of others 'construct an imaginary wider community of like minded individuals amongst whom the bereaved person can feel at home, symbolically aligning his or her biography with that of other members of the imagined community of the bereaved, who ultimately rejoin the world of the living.' (Seale 1998: 198, see also Anderson 1991)

But semi-psychiatric terminology can also be rejected. Holloway (1990: 23) describes the response of one of her clients to the books she was recommended to read:

She jumped at the chance to read books by other women who had been through similar grief, and she read three books which she said put into words much of what she had been feeling. One book which I gave her to read, which was more of an analytical description of bereavement, she claimed to have been no help whatsoever.... She raced to the end of the Jill Truman book to see how she was coping with her grief when years rather than months had elapsed, hoping to receive some encouragement that the passage of time would dull the pain.

This reader wanted some idea of grief's timetable, but wanted to learn about it from personal narrative rather than from theory.

A number of mourners (especially those in self-help groups - see below) reject stage theories. It is remarkable how many do so on the grounds that their own grief has not progressed in a simple unilinear path - they seem unaware that all the leading stage theorists agree with them on this! As one white, working class mother said:

I've read all that stages of grief stuff. I've read everything on death and dying. I can relate to what they say but none of it is me. Mothers don't get over their grief. They don't do it in stages. You just cross over and go back. It's like a circle, when you go round it once, you go back round it again. You do your own thing. (Quoted in Cline 1996: 193)

Mourners such as this may have been sold a bowdlerised, overly linear version of stage theory by an intermediary (an article in a woman's magazine, a doctor, a college tutor, or another bereaved person);ⁱⁱⁱ or they may themselves have read an account of stage theory which does highlight the lack of any simple progression, but at the time the reader was so desperate for clear guidelines that they read simple progression into the text when none was there. The map they thus created in their minds was subsequently disconfirmed by their own experience.

We may conclude from this brief discussion that some mourners resist psychiatric theorising about grief, but some others tie concepts deriving from such theories into highly personal first-person accounts and even use them to structure those accounts. Contemporary bereavement literature is, as I will show in the rest of the article, permeated by the need of many to tell their story in the face of others who cannot or will not hear them, but those who police and prohibit such first-person stories are not necessarily, or even primarily, those using semi-psychiatric concepts.

POLICING GRIEF

In every society, the expression of grief is regulated by conventions and rituals which indicate how, and how much, mourners should speak about the dead and express their feelings. In this sense, grief has always been policed.^{iv}

Though historians and anthropologists have documented these conventions in a number of societies, they have not always recorded the extent such conventions are appreciated by mourners; there has perhaps been a tendency for anthropologists (less so for historians) simply to assume the rules of mourning to be socially and psychologically functional. We do know that by the end of the nineteenth century upper middle class Victorian women in Britain were beginning to resent the restrictions of formal mourning, a resentment fuelled at least in part by their growing desire for personal freedom and privacy (Morley 1971; Cannadine 1981; Taylor 1983). These twin themes of freedom and privacy in mourning, and the consequent collapse of socially required mourning, spread to other social classes in the first half of the twentieth century (Walter 1999: Chapter 8). By the end of the twentieth century, the term 'the grief police' has become a term of abuse for any who would presume to tell others how, or for whom, to grieve. In the widespread popular and journalistic scepticism about the expansion of counselling in Britain in the late 1990s, counsellors are particularly vilified as members of this unwanted police force; a hospice worker, for example, wrote to me in 1996 that on the death of his wife he was advised by his daughter 'Don't let the grief police get at you'. After the death of Diana, Princess of Wales in 1997, by no means everyone wanted to join in the

massive (and massively publicised) public mourning; Jack (1997: 18), for example, complained of 'a kind of floral fascism . . . a country patrolled by the grief police'.

If all known societies regulate grief through the policing activities of community, family and religion, the late twentieth century has witnessed a widespread opinion that such policing is illegitimate. I hope to document in this second half of the article that the demand of many contemporary bereaved people to tell their own story is made in the face of what they perceive as undue policing. I suspect their demand is fuelled less by the objective amount of such policing (which may be historically at a rather low level) than by the perceived illegitimacy of *any* such regulation. I will start by examining the most general level of culture, before progressively focusing on policing by families, by counsellors, and by self-help groups of ever-increasing specialisation.

Culture and gender.

Since mourners can become emotional when telling their story, whether others want to listen to them depends in part on whether the culture allows the expression of emotion (Rosenblatt *et al.* 1976). Mourners may want to speak of the dead (Walter 1996), but whether the dead may be included in everyday conversation depends on cultural norms. During the seven days of the Jewish *shiva*, for example, mourners are expected to discuss the deceased; but the North American Apache are not allowed to speak the name of the dead, while the Hopi express no desire to recall the memory of their deceased (Mandelbaum 1959). If the dead may be mentioned or addressed, there are likely to be rules as to how they may be included in conversation. In contemporary Britain there are such rules, though not total agreement over them. Some people consider one should not speak ill of the dead and many are unwilling to mention the dead if they think it will cause upset; yet at the same time, there is also a trend toward funerals in which the minister or officiant speaks about the dead person, and a sensitive truthfulness in such speech is appreciated by mourners.

In the mid-nineteenth century, grief was identified as a properly feminine condition. Simonds and Rothman (1992: ch.1) argue, I think correctly, that this was part of the feminisation of family life, of the emotions and of religion that occurred in North America and Britain at that time and that has continued well into the middle of the twentieth century. Women were believed to be - and in large measure were - more pious, family-oriented, emotional and prone to grief than were men. This led to very different expectations being laid on grieving males and females, men being expected to get back to work and master their grief (Jalland 1996), women (or at least those genteel women with the required leisure) being expected to give way to it during an officially imposed period of mourning within the privacy of the home. The late twentieth century, however, has seen a colossal march of women out of the home and into jobs and careers, not least into journalism and the mass media where their voice is now heard. And among many other things, women are talking publicly about how they grieve. The private is once more becoming public. So the grief we are hearing about nowadays is the grief of upper-middle class, educated women. Women telling their story of grief is part of the wider trend toward women telling their story, of whatever kind. It is part of a rejection of a patriarchal culture which would hide women's experiences and stories from public view.^v

It is also a rejection of a culture of emotional containment and control. The desire of some bereaved people to be more expressive with their emotions is part of a

wider cultural trend. Ralph Turner (1976) perceives a shift from defining the self in terms of commitment to institutional roles, to the self as an expression of impulses or feelings. Bernice Martin (1981) writing in the UK, like Robert Bellah *et al.* (1985) in the USA, identifies two kinds of individualism that profoundly shape the contemporary world: a meritocratic / instrumental / utilitarian version, and a romantic / expressive version. The former is strong in the commercial middle classes, engineering, politics and science, the latter among the professions, arts and social sciences, and among women, and is in the ascendancy.

Seale (1995) has documented a shift in the script for heroic dying, from one in which the person and their intimates display courage through stoicism and hiding their feelings to one in which they show courage through being aware and expressive (see also Hawkins 1990). This new script, he argues, is 'particularly suited to the conditions of late modernity, where the project of self-awareness is a central pre-occupation.' (Seale 1995: 610-11) Contemporary mourners are offered the possibility of a comparably heroic grief. The heroic mourner finds the courage to explore and express her painful feelings, reflexively monitors her progress (cf Giddens 1991) along a path of pilgrimage well-worn by the feet of countless other pilgrims and, fortified by their tales, eventually arrives at the goal of healing and resolution, from which she can return safely to everyday life, a changed woman who has grown through the experience. And once returned, like many a true pilgrim, she regales others on the way with her adventures.

Whether they are breaking free from patriarchal censorship or from a more general culture of emotional containment, it is professional females who are the most likely to wish, and/or have the opportunity, to tell their stories of grief. Other reasons that women are more likely than men to tell their grief story are that there are many more widows than widowers, and that the mother-child bond is often particularly intense, causing women who lose either their own mother^{vi} or a young child to feel more grief than do many (but by no means all) men (Walter 1999: ch.10).

The women's stories typically come across as both intensely personal and (if their hearers and readers identify) as somehow universal. They are not presented as specific to a gender, a culture, a time. So I as the bereaved hearer/reader either identify and feel relieved that someone has, on my behalf, articulated my feelings and at least part of my story; or I feel their story is not my story. One general practitioner in a working-class London practice mentioned to me that the typical published complaint of the widow not being asked out by friends since she no longer has a partner rings no bells with her patients because in their working-class culture women go out, if at all, with other women and not with their husbands. We will see more below of how first person accounts serve both to include and exclude, the excluded often feeling driven to tell in turn their story. It is not just medical accounts that exclude.

Families

According to the evidence in published bereavement autobiographies and in qualitative research material, the culture of containment is mediated primarily through other family members, through family norms and family dynamics. The main police officers of grief are other family members.

In the following quote, the policing was concerned to enforce a reasonable period of mourning:

My family were very nice for about six weeks - very understanding but I was terrible for months afterwards, I used to forget things - I was living in another world, it takes me a long time to get over things. Anyway in the end they just lost patience. My husband was really nasty about it, he said: 'For God's sake woman, what's the matter with you, I was never like that when my mother died - it's been months.' (Littlewood 1992: 87)

The notion that grief is best limited to a certain period of time characterises formal mourning periods in traditional societies, and has been legitimated by Geoffrey Gorer (1965) as psychologically healthy - though the period he specified is rather longer than that expected in many British and American households. Without a formally specified time, there may be little or no agreement as to what is appropriate. While many bereaved people value the support given, after a time, to re-engage in social activities or to take up paid work, 40 per cent of those Littlewood interviewed felt the withdrawal of emotional support to be premature.

In many accounts of the death of a child, the parents - because of gender differences or because of coming from families of origin with different coping styles - may grieve in different, often mutually incomprehensible, ways (Riches & Dawson 1997). He may keep his thoughts to himself, going off fishing for hours by himself or going to smoke a cigarette by the child's grave on his way to work; she may want to talk, and talk, and talk. Each thinks the other is not coping well.

Children and parents may not be able to handle the other telling their story, or preventing them from telling it. Laura Prince (1996) wrote an autobiography twenty five years after the accidental death of her thirteen year old brother. Laura had been sixteen at the time, and became increasingly aware of the consequences of the death of Mathew, who had been the one who held the family together. Why did she write the book? Because after his death the family never talked about Mathew or shared their feelings about his death; Prince wanted to break the silence, to tell her story and to tell Mathew's story. Her book, Breaking the Silence, implies that her family's silence about bereavement symbolises that of American society in general.^{vii}

Starting in the Victorian period and persisting through to the middle of the twentieth century, adults have protected children from the dangers of the adult world by keeping them in ignorance, thus maintaining their innocence (de Mause 1976; James & Prout 1990). Recent decades, however, have seen a trend away from this, with experts urging parents and teachers to protect children by informing them, most notably with regard to sex, sexual diseases and drugs (Sommerville 1982; Scraton 1996). To what extent parents have actually made this shift is not entirely clear. A significant concern of contemporary death education, represented in books such as Prince's, is that children grieve too and that adults should recognise this; children are not protected from grief by adults not talking about it in their presence. Just as it is dangerous to think that children are not in contact with the world of drugs, so - it is now argued - it is dangerous to think that they are not deeply affected when someone close to them dies. (Clark 1998)

Parents who inform their eight year olds about sex and drugs may nevertheless balk at sharing their grief with them, or eliciting their child's own grief. It may simply be too much for either party. The prematurely bereaved American widows studied by Silverman in the late 1960s complained that friends and family steered conversation away from the deceased because they did not want to upset, or

be upset by, the widow, yet many widows did precisely the same thing to their own children:

the needs of the children could not wait while the widow dealt with her own grief, yet her own grief interfered with her ability to be aware of their needs and at times prevented her from responding appropriately.... Children were open about their grief, and many widows had difficulty with this. One woman compared her children's questions to 'a knife being stuck in my throat'. At the same time, they did not want to burden their children with their own grief, and they would withdraw, inadvertently causing the children to lose both parents..... The widows rationalised that the children would be unduly upset by seeing their grief, and they tried to keep themselves from crying in front of the children..... The children responded to their mother's lead..... In another family, the widow reported that her daughters stopped talking about their father when they saw how upset she became. (Silverman 1986: 93-6)

People cannot cope with too much pain, so avoid painful conversations. Just as bereaved fathers can shut themselves off from their wives, so widows can shut themselves off from their children - with the same effect: the wife loses her husband as well as her child, the children lose their mother as well as their father. It can also work the other way around, with children shutting up their parents. After the death of his wife, C.S. Lewis recorded (1961: 11): 'I cannot talk to the children about her. The moment I try, there appears on their faces neither grief, nor love, nor fear, nor pity but the most fatal of all non-conductors, embarrassment.'

Shapiro (1994: 12) argues that families need a modicum of emotional equilibrium in order to function, and re-establishing this is necessary in the aftermath of a bereavement. But the loss of access to shared grief that this may entail, and the loss of both individual and family stories about both the death and the dead, may be acutely felt. In such families, given the increasing value that contemporary British media place on expressing emotions, it is not surprising if some mourners also believe emotional expression to be vital for psychological health and become desperate to find someone who will hear their story and/or accept their feelings.

If family norms and dynamics are a major reason why some mourners are not allowed to tell their story, another is that others who knew the deceased are physically not there, at least not on a day-to-day basis (Walter 1996). Prior to the twentieth century, the most common deaths were of children and of parents before the children had left home, so the chief mourners - parent(s) and other siblings - were typically still living under the same roof. With the vast reduction in child mortality, with most adults living long past the time when their (smaller) families have left home, with the geographical mobility of those who have left home, and with the separation of home and work, the typical mourner today is grieving an elderly spouse or parent, and does not see the other main mourners on a day-to-day basis. The elderly widow lives on her own; middle aged children are surrounded by neighbours and workmates who never met their mother; likewise the grandfather whose favourite grandson is killed in a traffic accident. Friends, colleagues and neighbours are likely to have a low threshold for listening to the story of one they never knew.

Counselling

If friends, neighbours and family are either unable or unwilling to hear the mourner's story, it is perhaps not surprising if increasing numbers are going to a professional stranger - a bereavement counsellor - who is willing to listen to the story and able to hold the emotion. Clients often speak of their relief at being able to talk and to weep without fear of judgement. Hoffman (1988) suggests that the role of therapists (not just grief therapists) is that of a friendly editor, helping clients re-write their self.

Jennifer Hockey, an anthropologist who trained as a Cruse counsellor, observes that

In describing their experience of grief, bereaved people are subjecting their own intense, inchoate emotion and their extensive personal memories to a process of selection and ordering. What emerges are external verbal forms which the counsellor in turn seeks to edit or clarify. The product is an account, existing outside of themselves, which the bereaved person then submits to further processes of interpretation.

(Hockey 1986: 334)

Although few bereavement counsellors in the UK have been trained to see their work as narrative therapy, a large proportion of the many I have encountered in training workshops recognise that one of their functions is to provide a space where the client can talk about the deceased and tell his or her story.

Gender is again significant. Cruse is the UK's biggest voluntary agency for bereaved people, concentrating by the 1990s on volunteer counselling. In 1997-8, 76 per cent of Cruse's 26,000 clients and 86 per cent of its 4,500 volunteers were female. The stories of grief that emerge in Cruse counselling are typically women's stories, edited by women. It is unclear whether men do not join Cruse (either as volunteers or as clients) because they grieve less, or because they cannot identify with the female way of telling stories and with the emotional disclosure that often goes with this (cf Schut et al 1997).

Sometimes counselling fails to help clients edit their account in ways they find appropriate. This leads me now to discuss self-help groups in which the mourner joins a face-to-face community of people she hopes have experienced what she has experienced.

Mutual-help Groups

Self-help bereavement groups are better termed mutual help groups (MHGs), in that they teach not self-reliance but the value of sharing stories and feelings with others who have suffered the same category of loss. MHGs typically reject popular culture with its norms of emotional control, getting over grief in a matter of weeks, and 'letting go' of the deceased. MHGs typically also reject counselling and the semi-psychiatric discourse of stages and resolution, of normal and abnormal grief. One could even go so far as to say that MHG members define their group precisely in terms of its rejection of these two bodies of knowledge. Stories abound in MHGs of uncomprehending friends, relatives and professionals who have not 'been there', that is, who have not themselves lost a child, or a sibling, or whatever category of loss permits entry to the group (Riches & Dawson 1996). A leading figure in the Lockerbie support group, whose son died on the crashed plane, told me how useless counsellors were, and how much better it was to talk to other Lockerbie people. Rock (1998: 143) describes how one speaker told a meeting of Support After Murder and Manslaughter, to murmurs of agreement: 'I was a bereavement counsellor, but until you've lost a child yourself, you know nothing!'

This self-definition of the group as non- or even anti-professional characterises not just those MHGs concerned with bereavement:

Implicit in the self-help thrust is a profound critique of professionalism... Traditionally, the professions have been characterized by (1) control of entry into the occupation; (2) colleague rather than client orientation in terms of standards; (3) an occupational code of ethics; and (4) a 'scientific-theoretical' basis for occupational activity... The entire ethos of the professional orientation is very different from the self-help orientation which is much more activist, consumer centred, informal, open, and inexpensive. (Gartner & Reissman 1977: 12-14)

MHG's rely on experiential rather than professional knowledge or academic research as the way to truth, and the most valued MHG members are those who can use their own experience to handle their own or others' problems (Borkman 1976; Klass 1988: 186).

Studies of bereavement MHGs, such as those by Klass (1988), Riches and Dawson (1996) and Rock (1998), concur that the communion experienced among those who have been through the same experience of loss can be powerful. The experience, for example, of losing a child has in the twentieth century become one that isolates a parent from other parents, and to join with others who have also lost a child can create an almost overwhelming sense of fusion. Here, at last, are people who understand, who know what it is like, who have experienced what I have experienced. In the group, experiential understanding has authority over abstract expertise or well-meaning but uncomprehending sympathy.

Not all bereaved parents, however, have had the same experience.

Those who have lost an adult child have different experiences from those who have lost younger children, and may even experience ageism from these younger parents. Jeanne Webster Blank (1998) lost her 39-year-old daughter to breast cancer. She researched and wrote her book about the grief of older parents because she felt isolated not only from her contemporaries who had not suffered such a misfortune, but also from the bereaved parents in the local chapter of The Compassionate Friends, most of whom had lost a baby or younger child. 'I found myself longing for someone whose experience coincided with mine, with whom I could compare my feelings and responses - someone who was not a grieving mother a decade younger than my Cathy.' (1998: 3) So she sent a nation-wide questionnaire to other TCF members who had lost an adult child; the sixty replies comforted her that she was not so abnormal in the length and severity of her grief. Their stories were not being told in the TCF chapters up and down the USA. (Interestingly, only 10 per cent of her respondents were fathers, suggesting that fathers' stories have still to be told, or perhaps that they do not want them told?)

A perceptive analysis of how the fusion experienced by some members of a bereaved parents MHG may leave others out in the cold, leading to fission as they set up their own new group, is found in Rock's (1998) detailed analysis of British MHGs for parents who have lost a child through homicide. TCF was formed in 1969 for all who had lost a child. By the 1980s, TCF was attracting some who had lost a child by murder, but they found themselves alienated from other TCF members. Their passionate hate for the murderer, equally passionate dismay at the criminal (in)justice system, and difficulty in extracting information from this system about exactly how their child died, were not shared by other bereaved parents. Parents of murdered

children could not empathise with the stories of those parents whose child had died of leukaemia, stories in which the child slipped peacefully away surrounded by family and attended by caring professionals. It was the emotion of hate more than any other than bound these parents together and isolated them from other bereaved parents. Parents of murdered children also find their own and their child's identity spoiled (Riches & Dawson 1998) - what was a thirteen year old doing out so late? why didn't you know where she was? These are the questions that the defence counsel asks in full view of the court and that they fear other parents are asking behind their backs. Nor did the parents of murdered children always find the volunteer helpers from Victim Support of much use: not victims themselves, their training equipped them to counsel those who had suffered property crimes but were hopelessly at sea with one whose child had been murdered. So POMC (Parents of Murdered Children) was formed as an offshoot of TCF, eventually becoming independent and re-forming as SAMM (Support After Murder and Manslaughter). These and related groups turned increasingly to campaigning for changes in a legal system that ignores them, making them into victims twice over: once at the hand of the murderer, and once at the hands of the judicial process.

But the process of fusion and fission did not stop there. Most murders are committed not by strangers, but by those who know the victim, and may even be close relatives. The black-and-white world of POMC could not handle the grey world of those grieving a child whose murderer was no vile stranger but a son or brother whom they were regularly visiting in prison and to whom they would remain emotionally attached for life. Aftermath was formed in 1988 as an MHG for 'the families of the serious offender' and includes a number where there is intra-family murder.

Bereavement MHGs are like Russian dolls, each nested within a slightly bigger one. The biggest doll is the community of the bereaved, with every appearance of unity and coherence, all going through 'the grief process'. But inside it is the smaller community of bereaved parents, with every appearance of unity and coherence. But inside it is the smaller community of parents who have lost a child through murder. And inside that is the even smaller community of parents who have lost a child through murder at the hands of a stranger. The creation of each doll is the work of those who fuse with others who have the same story, but each fusion excludes and hides a sub-group, who may (or may not) fuse to create their own, smaller, doll.

Another possible image is of the postmodern mourner as a nomad (Bauman 1992), wandering here and there until she finds someone who will hear her story. This image, however, is almost certainly misleading. Few mourners have the stamina to search consistently. It is usually a matter of chance which group or groups they encounter; if the story fits, all well and good. If the story does not fit, they are more likely to return to isolation, or move on to, at most, one other group.

CONCLUSION

There is a danger in social science in confusing the attempt by medicine to colonise an area of human experience with successful colonisation. Certainly in some cases the colonisation is effective, as with childbirth where virtually all pregnant women routinely consult medical clinics and where most births take place within hospital. But in other areas, the colonisation is very far from complete. Just because homosexuality was medically identified (before its legalisation) as a psychiatric

abnormality does not mean that most homosexuals were terrified of being incarcerated in a psychiatric institution; stigma at the hands of friends, family and employers may have provided much more effective policing of their everyday life. This stigma was based more on the belief that homosexuality was disgusting or sinful than that it was a sickness. Likewise the contemporary identification of eating disorders as psychiatrically treatable is not the main reason that bulimics hide their habit: they are more often afraid their parents will think it disgusting or that partners will abandon them.^{viii} So too with grief: it seems that grief's medicalisation is just one, and by no means the most powerful, way in which mourners are policed.

Clearly, there is an extent to which grief has been medicalised. This is evident in the psychiatric basis of many theories about grief, in the diffusion of semi-psychiatric terms into the everyday language of mourning, and in the relatively high proportion of mourners who visit their family doctor for medication or in the hope of having someone to talk to. It is also clear that the strong drive of mourners to tell their own story, unedited and unpoliced by others, is in part driven by resistance to the semi-psychiatric terminology of 'resolution', 'stages' and 'denial' that pervades a significant proportion of the professional and volunteer help on offer. This is particularly true of the anti-professional rhetoric of mutual help groups. But it is equally clear that the urge 'to tell my story' is driven by resistance to a range of other policing activities. Family dynamics, the experience of other bereaved people, and a general culture of containment can all be experienced as invalidating and/or silencing my own story. Face-to-face policing by those met daily in everyday life has an immediacy that differentiates it from policing by the abstract concepts introduced into mourning by psychiatry. Resistance to medicalization thus constitutes only a part of the struggle of mourners to find a voice.

Indeed, the culture of expressivism that encourages mourners to go public with their emotions and their stories derives in part from Freudian and other psychiatric and semi-psychiatric theories which praise the healing value of emotional disclosure. At this point, Arney and Bergen (1984) and Armstrong (1987) rather than Frank (1995) are nearer the mark. The patient's story is not so much a heroic resistance to medicalisation; rather, medics themselves have encouraged patients to be more open about their inner secrets, and nowhere more successfully than with dying patients. There certainly is an element of this in the relationship between psychiatric theories of grief and mourners' demands to tell their story.

In all this, of course, many mourners wish to continue to grieve in private, to keep their stories and their memories to themselves (Walter 1999: ch.8). They are disturbed by the trend away from a culture of containment in which mourners are censured for telling their story toward an expressive culture in which mourners are encouraged to tell their story and censured for 'bottling up their feelings'. Expressivism is making a bold challenge to the culture of containment, but not without resistance (e.g. Anderson and Mullen 1998). Whether expressivism will succeed in becoming the dominant culture, with all that will mean for storytelling, only time will tell. The other (more tolerant, perhaps postmodern?) possibility is that mourners really will be left free to grieve their own way, to talk if they want to, to maintain their privacy if they want to. But there is no historical precedent for such a society, and the data I have presented on family dynamics and on the dynamics of mutual help groups suggest that human groups will always develop norms for how grief may, or may not, be talked about, and these norms will always be policed.

Bauman (1997) argues that traditional societies, and to an extent modern ones too, provide security at the expense of personal liberty; postmodernity, by contrast, celebrates difference and personal freedom at the expense of security. His analysis certainly fits the phenomenon of mourning. Traditional societies typically police mourning through religious and community-enforced norms. Modernity, with its ideals of personal liberty, especially for women, undermined these norms but to some extent replaced them with expert psychiatric definitions of healthy grieving which likewise provide a map of the convoluted terrain of grief. In postmodern times, both the old and the new maps are challenged by those who claim no maps can be made of a land that is entirely subjective and individual (Stroebe et al 1992). And indeed, contemporary American and British mourners probably have more freedom to grieve as they will than has been the case in any known society; it is this taste of freedom that causes some to resent so bitterly the policing of their grief. Yet the evidence presented in this article also suggests that the desire (of both mourners and their comforters) for security, for a map, for fellow travellers, for rules that must be policed, is sufficiently strong that most mourners will never be allowed to be entirely free spirits. Modernist medicine is but one section of the force that polices, and will continue to police, them.

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ⁱ Her major work concerns the dying, but her stage theory has been very influential in subsequent thinking about bereavement.

ⁱⁱ I draw the term 'semi-psychiatric' from Perakyla (1988).

ⁱⁱⁱ For an example, written by a family doctor in the popular UK magazine *Radio Times*, see Porter (1996).

^{iv} The source of my concept of policing is Durkheim's notion of the need of society to regulate the passions (1952). Links could also, of course, be made with the work of Foucault (e.g. 1973).

^v The discovery in the 1990s of ‘the emotional male’ means that men’s stories of grief are now also being told.

^{vi} Women losing a parent is the second largest category of client that Cruse currently works with, almost replacing the widow as the typical client (Cruse national statistics, 1997-8). The loss of a child-minding grandparent may represent for increasing numbers of working mothers a practical and financial, as well as personal, loss.

^{vii} It is unclear to what extent Prince had felt the family prevented her talking about Mathew at the time. Most of the insights in the book date from after she entered therapy, so this is the account that emerged in the therapy room, a room to which the other family members were never admitted, and therefore it carries all the problems of retrospective recall of emotional abuse.

^{viii} See ongoing doctoral work by Dawn Clarke, Dept of Sociology, University of Reading.